

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11178

CERTIFICATE OF DEATH

11167

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ridgely				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ridgely			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) None				d. STREET ADDRESS Central Ave.			
3. NAME OF DECEASED (Type or print) First Grace Middle P. Last Cannon				4. DATE OF DEATH Month 8 Day 21 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-30-1888	
9. AGE (in years last birthday) 77 yrs.		10. UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None			
13. FATHER'S NAME Alexander Parris				14. MOTHER'S MAIDEN NAME Letecia Bailey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 214-32-2343			
17. INFORMANT Ruth Garey Ridgely, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Parkinson's Disease 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)							19. INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Decubitus Ulcers							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1 , 19 66 , to Aug. 21 , 19 66 , that (I) (we) last saw the deceased alive on Aug. 20 , 19 66 , and that death occurred at 2:30 PM from the causes and on the date stated above.							
22a. SIGNATURE Charles H. Storesifer				22b. DATE SIGNED Aug. 23 '66		22c. PHYSICIAN'S NAME (Type) Charles H. Storesifer, M.D.	
22d. ADDRESS Greensboro, Md.				22e. REC'D BY REGISTRAR AUG 29 1966		22f. REGISTRAR'S SIGNATURE Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-24-66		23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City, town or county) (State) Greensboro, Maryland	
24. FUNERAL DIRECTOR J. E. Boulais, Greensboro, Md.							

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Caroline

Caroline

Caroline

Address

City

State

General Ave.

None

Grace

Grace

Grace

White

White

White

None

None

Alexander Smith

Alexander Smith

White

White

None

White

White

White

White

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White

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11179		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				11168			
1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - PRESTON			c. LENGTH OF STAY IN lb 6 MONS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRESTON - RURAL				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MD ROUTE #331					d. STREET ADDRESS RFD			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLAYTON Middle COVEY Last CARROLL			4. DATE OF DEATH Month AUGUST Day 21 Year 19 66						
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 30, 1937		9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEVER HELD JOB			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) DELAWARE			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY L. CARROLL					14. MOTHER'S MAIDEN NAME GERTRUDE COVEY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT HARRY L. CARROLL Address PRESTON, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of cervical vertebrae 8124 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of the skull DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH minutes minutes as
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Lacer Report on Blood Alcohol									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit by a car while walking on the road						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2:15 PM 8/21/66			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 331		20f. (City or town) (County) (State) RFD Preston Caroline MD		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Harold B. Plummer M.D.					22. DATE SIGNED 8/22/66				
EXAMINER'S NAME (Type) Harold B. Plummer MD.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF AUG 24, 1966		23c. NAME OF CEMETERY OR CREMATORY JUNIOR ORDER CEMETERY		23d. LOCATION (City or Town) (County) (State) PRESTON CAROLINE MD		
24. FUNERAL DIRECTOR FRAMPTON FUNERAL HOME, FEDERALSBURG, MD					25a. REC'D BY REGISTRAR DATE AUG 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

11108

11170

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11180

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11169

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton			c. LENGTH OF STAY IN 1b 25 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 323 South Second Street					d. STREET ADDRESS 323 South Second Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Frank Last Lane Jr.				4. DATE OF DEATH Month August Day 5 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 11, 1914		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant - The Nuttle Lumber & Coal Co.			10b. KIND OF BUSINESS OR INDUSTRY Goldsboro, Maryland		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME J. Frank Lane				14. MOTHER'S MAIDEN NAME Margaret Scott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-20-4713		17. INFORMANT Mrs. Caroline M. Lane, Denton, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Artery Sclerosis DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 hrs 10 yrs 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Harold B. Plummer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED Aug. 6, 1966	
EXAMINER'S NAME (Type) Harold B. Plummer, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 7, 1966		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland	
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR AUG 11 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

11103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 9 Film G380 9/15/66 12554											
1. PLACE OF DEATH a. COUNTY Caroline MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greensboro				c. LENGTH OF STAY IN 1b 21 da.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Hollin's Nursing Home						d. STREET ADDRESS 09-2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fannie			First Fannie Middle McCready Last McCready			4. DATE OF DEATH Aug. 25 1966			Month Aug. Day 25 Year 1966		
5. SEX F		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> UNK. DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unk.		9. AGE (in years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Mayland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unk.						14. MOTHER'S MAIDEN NAME Unk.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.				16. SOCIAL SECURITY NO.		17. INFORMANT Dorchester Welfare Board				Address Camb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. Disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 5 , 1966 , to Aug. 25 1966 that (I) (we) last saw the deceased alive on Aug. 24 1966 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE Charles H. Stoner M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Charles H. Stoner, M.D.						22b. DATE SIGNED Aug. 26 '66					
22d. ADDRESS Greensboro, Md. 21639											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/8/66		23c. NAME OF CEMETERY OR CREMATORY Waugh		23d. LOCATION (City, town or county) (State) Cambridge Maryland			
24. FUNERAL DIRECTOR Frederick C. Delair						ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR SEP 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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11170

Item 4 Film G380 9/9/66 mh

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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1. PLACE OF DEATH a. COUNTY CAROLINE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL DENTON c. LENGTH OF STAY in 1b life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL DENTON d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDNA Middle ELIZABETH Last NEAL		4. DATE OF DEATH Month August Day 30 Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 15, 1896
9. AGE (in years last birthday) 69 yrs.		10. AGE (in years last birthday) 69 yrs.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DOWN VICKERY		14. MOTHER'S MAIDEN NAME ELIZABETH PORTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. EDNA NEAL, DENTON, MD.	
17. INFORMANT EDNA NEAL, DENTON, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: Pulmonary embolism 466X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last: Thrombosis of iliac veins with surrounding hemorrhage			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John W. Rieckert		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John W. Rieckert		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 2, 1966	
22c. NAME OF CEMETERY OR CREMATORY DENTON		22d. LOCATION (City, town, or country) (State) DENTON MD	
23. FUNERAL DIRECTOR J. VERARD MOORE		ADDRESS DENTON, MD.	
24a. REC'D BY REGISTRAR SEP 2		24b. REGISTRAR'S SIGNATURE Charles Judge	

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General Denton
Colonel Denton

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. To burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 11171									
1. PLACE OF DEATH a. COUNTY Caroline b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg, R. F. D. c. LENGTH OF STAY IN b 2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg, R. F. D. d. STREET ADDRESS none e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First William Middle Shanley Last Roe					4. DATE OF DEATH Month August Day 17 Year 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 30, 1894 71 yrs.		9. AGE (In years last birthday)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber man		10b. KIND OF BUSINESS OR INDUSTRY Retired lumberman		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William A. Roe					14. MOTHER'S MAIDEN NAME M. Laura Calloway				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 42I-24-275I-A		17. INFORMANT Cornelius Roe		Address Lutherville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery Sclerosis DUE TO Generalized arteriosclerosis (c) 204								INTERVAL BETWEEN ONSET AND DEATH minutes 65 years 204	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Harold B. Plummer					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) Harold B. Plummer					DATE SIGNED 8/19/66				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 19		22c. NAME OF CEMETERY OR CREMATORY Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Harold B. Plummer					24a. REC'D BY REGISTRAR AUG 24 1966		24b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM	
TOXICOLOGY		PATHOLOGY		BACTERIOLOGY		ANTHROPOLOGY	
FORENSIC		LABORATORY		HISTOLOGY		CYTOLOGY	
IMMUNOLOGY		GENETICS		PHYSIOLOGY		PSYCHOLOGY	
SOCIOLOGY		LAW		POLICE		JUDICIARY	
MILITARY		NAVY		ARMY		AIR FORCE	
MARINE CORPS		COAST GUARD		FISH AND WILDLIFE		NATURAL RESOURCES	
HISTORICAL		ARCHAEOLOGY		ETHNOLOGY		LINGUISTICS	
LITERATURE		ARTS		SCIENCE		TECHNOLOGY	
MEDICINE		NURSING		DENTISTRY		VETERINARY	
PHARMACY		OPTICIAN		PODIATRIST		CHIROPRACTIC	
ACUPUNCTURE		YOGA		MEDITATION		ENERGETICS	
HERBAL MEDICINE		DIETETICS		NUTRITION		FOOD SAFETY	
WATER QUALITY		AIR QUALITY		SOIL QUALITY		CLIMATE	
ENVIRONMENTAL		POLLUTION		WASTE MANAGEMENT		RENEWABLES	
SUSTAINABLE		DEVELOPMENT		URBAN PLANNING		TRANSPORTATION	
INFRASTRUCTURE		HOUSING		ENERGY		WATER SUPPLY	
TELECOMMUNICATIONS		INFORMATION TECHNOLOGY		COMMERCE		INDUSTRY	
FINANCE		LAW		POLITICS		GOVERNANCE	
PUBLIC ADMINISTRATION		LOCAL GOVERNMENT		STATE GOVERNMENT		FEDERAL GOVERNMENT	
INTERNATIONAL		DIPLOMACY		TREATIES		ORGANIZATIONS	
NON-PROFIT		FOUNDATIONS		CHARITIES		RELIGIOUS	
EDUCATION		RESEARCH		DEVELOPMENT		INNOVATION	
CULTURE		HERITAGE		LANGUAGE		IDENTITY	
VALUES		BELIEFS		ETHICS		MORALS	
LIFESTYLE		BEHAVIOR		ATTITUDES		OPINIONS	
PREFERENCES		INTERESTS		HOBBIES		PASTIMES	
LEISURE		SPORTS		GAMES		ARTS AND CRAFTS	
CULINARY		GARDENING		FISHING		HUNTING	
TRAVEL		ADVENTURE		RELAXATION		REFLECTION	
MEDITATION		YOGA		MINDFULNESS		TRANSFORMATION	
GROWTH		CHANGE		EVOLUTION		PROGRESS	
ACHIEVEMENT		SUCCESS		FULFILLMENT		WISDOM	
KNOWLEDGE		UNDERSTANDING		WISDOM		TRUTH	
FAITH		HOPE		CHARITY		LOVE	
COMPASSION		KINDNESS		PATIENCE		SELF-CONTROL	
TEMPERANCE		MODERATION		BALANCE		HARMONY	
PEACE		STABILITY		ORDER		UNITY	
COOPERATION		TEAMWORK		COLLABORATION		SYNERGY	
INFLUENCE		LEADERSHIP		MANAGEMENT		ORGANIZATION	
STRUCTURE		SYSTEMS		PROCEDURES		PRACTICES	
METHODS		TECHNIQUES		SKILLS		KNOWLEDGE	
EXPERIENCE		PRACTICE		MASTERY		PERFORMANCE	
RESULTS		OUTCOMES		IMPACT		LEGACY	
CONTRIBUTION		HERITAGE		INFLUENCE		WISDOM	
WISDOM		TRUTH		LOVE		PEACE	
HARMONY		UNITY		COOPERATION		TEAMWORK	
COLLABORATION		SYNERGY		GROWTH		CHANGE	
EVOLUTION		PROGRESS		ACHIEVEMENT		KNOWLEDGE	
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CHARITY		LOVE		COMPASSION		KINDNESS	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND b. COUNTY CAROLINE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DENTON				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DENTON			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) life				d. STREET ADDRESS 65-1			
3. NAME OF DECEASED (Type or print) First Middle Last EDNA WICKLINE SHIPMAN				4. DATE OF DEATH Month Day Year AUG 7 1966			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR 22, 1884		9. AGE (in years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL SERVICE		10b. KIND OF BUSINESS OR INDUSTRY POST OFFICE		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME STEPHEN SHIPMAN				14. MOTHER'S MAIDEN NAME HANNAH COOKSEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. NO			
17. INFORMANT Address MRS. J. H. DELORA, GLOUCESTER, VA.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Chronic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Secondary Anemia (b) 4344 (c) 1 mos							INTERVAL BETWEEN ONSET AND DEATH 1 days 4 yrs 1 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1960 to Aug 1966 , that (I) (we) last saw the deceased alive on Aug 5 1966 , and that death occurred at 1 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE Dawson George				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 8-9-66		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dawson George				22d. ADDRESS Denton, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG. 9, 1966		23c. NAME OF CEMETERY OR CREMATORY DENTON		23d. LOCATION (City, town or county) (State) DENTON MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. V. DRIGL MOORE & SON ADDRESS DENTON				25a. REC'D BY REGISTRAR AUG 12 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11185					11173				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Caroline MARYLAND					a. STATE Maryland b. COUNTY Caroline				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Feddersburg				c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Feddersburg				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brooklyn Avenue					d. STREET ADDRESS Brooklyn Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First Samuel Middle Garfield Last Turner		4. DATE OF DEATH		Month August Day 6 Year 19 66		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1885		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Day Laborer			10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (County & State, or foreign country) Feddersburg, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry Richards					14. MOTHER'S MAIDEN NAME Leona Johnson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 215-18-4499		17. INFORMANT James G. Turner, Feddersburg, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Coronary heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 1 hour several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 6		
21. I certify that (I) (this hospital) attended the deceased from June 16, 19 66 to August 6, 1966 , that (I) (we) last saw the deceased alive on 8-6-66 19, and that death occurred at 5:25 PM , from the causes and on the date stated above.									
22a. SIGNATURE Frank M. Anderson M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug. 8, 1966		
22c. PHYSICIAN'S NAME (Type) Frank M. Anderson, M.D.					22d. ADDRESS Feddersburg, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Aug. 10, 1966		23c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		23d. LOCATION (City, town or county) (State) Feddersburg, Maryland		
24. FUNERAL DIRECTOR J. S. Brampton and Son, Feddersburg, Maryland					25a. REC'D BY REGISTRAR AUG 11 1966				
					25b. REGISTRAR'S SIGNATURE Charles Judge				

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES AUGUSTUS WILLOUGHBY</u>		4. DATE OF DEATH Month Day Year <u>AUG 16 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 21, 1881</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK WILLOUGHBY</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA COALBOURNE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>NORMAN WILLOUGHBY, DENTON</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>Malnutrition, Arterial Sclerosis</u> DUE TO (c) <u>Atherosclerosis, Chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 yrs</u> <u>7 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-29</u> , 19 <u>66</u> , to <u>7-28</u> , 19 <u>66</u> , that (I) (we) lost the deceased on <u>7-28</u> , 19 <u>66</u> , and that death occurred at <u>11:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dawson O. George</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>8-19-1966</u>
22c. PHYSICIAN'S NAME (Type) <u>Dawson O. George</u>		22d. ADDRESS <u>Denton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Aug. 20, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DENTON HOLYCROSS</u>	23d. LOCATION (City or Town) (County) (State) <u>CAROLINE MD</u>
24. FUNERAL DIRECTOR <u>J. STROFF MOORE</u>		25a. REC'D BY REGISTRAR <u>Denton</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>AUG 23 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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INVESTIGATION OF DEATH

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Warrant for arrest of

John Doe, alias

John Doe, alias

John Doe, alias